

James (M. L.)

OBSERVATIONS

ON

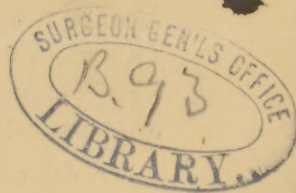
Amphoric Respiration

AND

AMPHORIC RESPIRATORY ECHO.

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PRESIDENT RICHMOND ACADEMY OF MEDICINE.



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PROCEEDINGS

RICHMOND ACADEMY OF MEDICINE.

Observations on Amphoric Respiration and Amphoric Respiratory Echo.

Reported by C. K. GARDNER.

The president of the Academy, Dr. M. L. James, presented a pathological specimen of a lung, which, in life, had afforded a very marked *amphoric respiration*, occupying nearly one entire side of the chest. The lung showed a very large phthical cavity, with a smooth internal surface, the front wall being made of a much thickened pleural membrane, closely adherent to the parietal walls, as it was nearly throughout the whole extent of that cavity, the result of adhesive inflammation. The rear wall was composed of a like adherent pleural membrane, with about an inch thickness of lung, which had lost its characteristic pulmonary structure, and was left in a carnified condition.

Dr. James expressed his conviction that such adhesion of the pleural surface of a cavity with the chest wall, was the usual condition by which amphoric respiration is produced, and has been surprised to see no mention made by the authorities of such a condition, as the occasion of the production of this abnormal sound. The authorities recognize the existence of a large cavity with firm walls, as the occa-

sion of amphoric respiration, but he has no where seen any account where pleural adhesion has been the particular circumstance by which those walls were made thus firm. Dr. James believes that this, though not the exclusive, is the usual mode.

Dr. James also reported a case of *Respiratory Amphoric Echo*, which had occurred in a case of chronic pleurisy with empyema, in which pneumo-thorax of the affected side had been established by a free opening made through the parietes of the chest to allow the escape of the large amount of pus which had been formed. In this case there had been no communication between the pleural cavity and bronchial tubes, there being no phthisical cavity, or other perceptible disease of the lungs, except the pleurisy referred to. The amphoric sounds occurred after the pneumo-thorax had been established by the operation, and were clearly produced by the communicated vibrations, from the passage of air along the bronchial tubes to that contained in the pleural cavity.

It differed from the amphoric sound produced by the direct entrance of air into phthisical cavities, in the fact that it occurred at a short, but appreciable interval, after the inspiratory act, was more prolonged in its utterance, being indeed, rather a succession of reverberations, and susceptible of being recognized by its echoing quality of sound. For that reason, Dr. James described it as an amphoric respiratory *echo*.

The case was interesting as demonstrating the fact that sounds of an amphoric quality may be produced without the direct passage of the air of inspiration into a cavity, and that they are marked by distinctive characteristics, susceptible, under close attention, of recognition.

